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NOTES ON DRUG ERUPTIONS.*

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I DESIRE to briefly report to the association some cases showing the more unusual manifestations of the effect of drugs on the cutaneous surface.

Case I. The Nodular Form of Iodic Eruption.—The patient, a woman aged thirty-seven, was admitted to my service in the City Hospital in March, 1893, suffering from a hemiplegia of some years' standing, the result of an old syphilitic infection. She was given the iodide of potassium in increasing doses. While taking sixty grains three times a day, two and a half weeks after her admission, two painful and indurated nodules appeared in the subcutaneous tissue on the anterior and posterior surfaces of the right thigh, the paralyzed member.

Under the continued use of the iodide for the next two or three days they increased rapidly in size until they became larger than a man's fist, extending deeply into the subcutaneous tissue and involving a surface area about five inches in diameter. The overlying skin was reddened, and the swellings became softer, simulating deep-seated abscesses.

During the development of the larger swellings a similar but smaller one appeared on the anterior surface of the left thigh.

The house physician at the time directed my attention to the swellings, which he had called "peculiar abscesses." They were looked upon by me as due to the ingestion of the iodide of potassium, and its use was discontinued. Within a day or two the swellings began to subside, and at the end of a week had completely disappeared.

It was my intention to have again administered the iodide in order to determine conclusively its ætiological connection with the swellings in question. The patient, however, demanded her discharge from the hospital, and I was unable to verify my diagnosis.

I find in Morrow's work on *Drug Eruptions* references to similar subcutaneous swellings due to the administration of the iodide, by Vallanur, Talamon, Hallopeau, and Pellizari. In Hallopeau's case the localization of the nodular swellings was similar to that in my own case. Talamon mentions the close resemblance which the eruption in

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his case bore to erythema nodosum. In my own case this comparison could scarcely be made, as the tumors were much larger than those usually seen in erythema nodosum; they were not accompanied by swelling or pain in the joints, and disappeared sooner than the latter eruption is accustomed to do.

As it is quite probable that all the eruptions due to the iodides are secondary to certain vascular changes which the drug is known to produce, it seems reasonable to suppose that the sluggish circulation in the paralyzed leg might in part have been responsible for the severer character of the swellings on that side.

Cases II and III. Rupialike Eruptions due to the Iodide of Potassium.—I have lately observed two examples of an eruption due to the internal administration of iodide of potassium, both of which closely simulated syphilitic rupia, and in one of which the drug eruption could scarcely be distinguished from the syphilide which was present at the same time.

One of the patients, a girl aged twenty, was taking a mixture containing ten grains of the iodide and a sixteenth of a grain of bichloride of mercury for an extensive rupial syphilide. After the administration of the mixture for a period of several weeks, and while the syphilitic eruption had almost healed, three or four rounded, crusted, brownish-red papulo-pustules, about the circumference of a silver dime, appeared on her forehead and cheeks. On removing the crusts the underlying skin in certain lesions presented an irregular granulating base, almost papillary in character, while in others the base was more elevated and fungouslike.

The further administration of the iodide was followed by an increase in the size of the ulcerated surfaces, and by the occurrence of new lesions, which were observed to begin as brownish-red tubercles on which vesicles developed that rapidly became pustular. The secretion dried in the form of superimposed dark-colored crusts, the ulcerated base at the same time extending in circumference as in syphilitic rupia.

The use of all specific remedies was discontinued, and the sores treated by a boric-acid ointment, under which they rapidly healed, leaving brownish-red pigmented scars, which could not be distinguished from the scars left by the former syphilide. After a period of several weeks the iodide alone was given, and with a similar result.

Case III.—A man, aged twenty-nine, affected with a gummatous syphilide of the chest and arms, was given a mixture similar to that employed in the former case.

When the specific eruption was rapidly disappearing a number of

ulcers with irregular depressions over their surfaces, and undermined edges, were noted on the forehead, cheeks, and upper lip.

The ulcers were preceded by an infiltration, brownish-red in color, which became pustular, and rapidly developed into open ulcers.

The ulcers were about an inch in diameter, and healed on stopping the iodide under an antiseptic ointment. They were at first mistaken for a new syphilitic outbreak, and were treated more vigorously with the iodides and mercury. They became larger under this treatment, while new lesions of like character developed.

Irregular pigmented scars were left, as in the former case.

The eruption in both of these patients corresponded closely with the anthracoid variety of the iodide eruptions. It differed, however, in the absence of the multiple openings or pustular points; and, in the case first reported, by the great quantity of superimposed crusts, giving it the physiognomy of a rupia.

Both of these cases, however, can be classed under the heading of the anthracoid form of iodide eruptions, and are referred to more particularly to emphasize their close resemblance to rupia. Such observations seem to demonstrate that the skin may, under certain conditions, respond in an almost identical manner to the chemical agent iodine and to the poison generated by the syphilitic virus.

Case IV. Erythema Scarlatiniforme following the Application of Mercurial Ointment to the Pubic Region.—A young man of twenty years presented himself at my clinic with a universal, diffuse, erythematous rash, involving alike the face and all portions of the cutaneous surface. The eruption closely simulated that of scarlatina, and in fact had been so diagnosticated by a physician who had seen him before.

The temperature was not elevated, and there was no implication of the throat. After stripping him I noticed that the skin about the pubic region was stained from the application of mercurial ointment, which, he said, he had used a few days before as a remedy for pediculi. Within two days after the application he had noticed the rash, which itched slightly, but otherwise gave him no trouble. I saw the patient again within a week, when abundant desquamation was taking place over the entire body, and especially noticeable on the hands and feet.

Case V.—The colored photograph which I present (photograph shown) illustrates the distribution of a diffuse and scattered erythematous rash which followed the application of blue ointment to the pubic region for the same purpose as that employed in the case just quoted. The diffuse erythema extends as high as the nipple line in front and behind, and as low as the knees. The rash is also diffuse on the inner aspects of the arms.

On the chest, both back and front, scattered patches of multiform erythema are seen, as well as on the arms and legs. On the back a circinate patch of erythema is seen, made by the confluence of smaller patches.

Desquamation of the affected surface followed within a few days, as in the other case.

In both of the patients the eruption was purely erythematous, with no formation of vesicles and very little swelling of the skin. Similar eruptions have been reported after the internal use of the drug, the protiodide and calomel (Fournier and Engleman), the hypodermic employment of calomel (Lesser), following the application of corrosive-sublimate dressings, and from exposure to the fumes of mercurial vapor. The application of mercurial ointment to the skin is more frequently followed by a papulo-vesicular eruption, which is more marked around the hair follicles. In an experience of several years at Hot Springs, where the inunction treatment of syphilis is almost exclusively employed, I do not recollect having seen such an extensive erythematous rash as in either of the cases reported.

Case VI. Erythematous Eruption from the Internal Use of Boric Acid.—A female patient in the City Hospital under my care was given boric acid in doses of thirty grains daily for the period of a month for a cystitis. At the end of this time she developed a multiform erythema of the trunk, more noticeable over the back and shoulders, and at the same time a marked swelling of the upper lids. The lids were painful, and the œdema so extensive as to cause them to be closed.

There was also a marked conjunctival inflammation and decided photophobia. Not suspecting that the boric acid was responsible for the condition, its use was continued. The erythematous eruption in the meantime spread over the trunk and upper extremities, and the painful œdema of the eyes increased until the lids became almost as hard as the induration of the initial sclerosis.

The boric acid was discontinued at this time, and cold applications made to the eyes. Within a short time the œdema of the lids began to grow less, and within a week had entirely disappeared, the erythema passing away at the same time.

Eruptions of an erythematous, vesicular, and bullous type have been reported from the administration and local use of boric acid. One observer has noted the occurrence of conjunctival injection.

I find no mention, however, of the peculiar solid œdema of the lids which my patient presented in such a marked degree.

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